PATIENT INFORMATION QUESTIONAIRE

Please provide the information requested below. This becomes part of your records and remains strictly confidential.
PLEASE PRINT!

Name: _____ DATE COMPLETED: _____

Local Address/City/State/Zip: _____

Alternate Address/City/State/Zip _____

Home phone: _____ Work phone: _____ Cell : _____

Age: _____ DOB: _____ Height: _____ Weight: _____ Eye Color: _____

Social Security #: _____ Occupation: _____

Employer: _____

Spouse/Parent/Guardian: _____

Family Physician/PCP: _____ Telephone: _____

Name of person who referred you here: _____

Preferred Pharmacy: Name: _____ Phone: _____

Address: _____

INSURANCE INFORMATION

Medicare # : _____

Other or Secondary Insurance: _____ ID#: _____ GRP# _____

MEDICAL INFORMATION

PACEMAKER OR DEFIBRILLATOR : Yes _____ No _____

Current skin problem: _____

Past Medical History (check all that apply)

____Antibiotics prior to dentistry
____Artificial joints or heart valves
____Autoimmune disease
____Cancer history
____Diabetes
____Glaucoma
____Hepatitis
____HIV
____High blood pressure
____Immunosuppression
____Keloid history
____Nursing a baby
____Pregnant
____Skin cancer
type (circle): basal cell carcinoma
squamous cell carcinoma
malignant melanoma
abnormal moles

____Allergy problems
____Bleeding problems
____Joint problems

____ Alcohol use
____ Tobacco use

Family history of:
_____Skin cancer
type (circle): basal cell carcinoma
squamous cell carcinoma
malignant melanoma
unknown
____ abnormal moles

date/ body location (if known):
_____
_____
_____
_____

Medications: _____
_____
_____

Allergies: _____

Your Signature: _____ (Authorization for treatment)